



10550

EMERGENCY CONTACT	EMERGENCY PHONE	REL	ADDRESS
MONTGOMERY LISA	785 549-3548	2	BOX 85

MITTING DIAGNOSIS

DIARRHEA. DEHYDRATION

REMARKS

N/V/D VER GFD

CONSULTANTS

FINAL DIAGNOSIS	CONSULTANTS.
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PROCEDURES

I CERTIFY THAT THE NARRATIVE DESCRIPTION OF THE PRINCIPLE AND SECONDARY DIAGNOSIS AND THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Case 4:12-cv-08001-GAF Document 162-11 Filed 09/03/15 Page 1 of 15

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
1700 WEST 7th STREET
TOPEKA, KANSAS 66606-1690

DISCHARGE SUMMARY

NAME:	MONTGOMERY, KEVIN W	MR#:	10660
ROOM#:	7E-0704-2	DOB:	06/28/1960
ADM:	06/05/2001	PT:	I
DIS:	06/06/2001	MSV:	001
ACCT#:	2171894		

DISCHARGE DIAGNOSES:

1. Acute Campylobacter gastroenteritis.
2. Dehydration, secondary to #1.

CLINICAL HISTORY: Patient is a 40-year-old white male, who presented to the Emergency Room with a two day history of nausea and frequent loose watery stools. He had been seen the preceding day by Dr. Gerald Marcell in his office and had undergone stool culture studies, which were pending. He had failed attempt at outpatient management and because of his continued inability to take in oral fluids or food, he presented to the Emergency Room. He was evaluated and given his dehydration and continuing symptoms, it was elected to admit him.

Pertinent STUDIES this hospitalization: Admitting LABORATORY STUDIES revealed CBC unremarkable with WBC 9.9, hemoglobin 15.6, hematocrit 43.9, MCV 85.4. CBC on the second hospital day after hydration revealed WBC 6.3, hemoglobin decreased to 12.8, hematocrit 36.8. Stool for occult blood was positive X one. Chem B on admission showed BUN 11, creatinine 0.9. Liver function tests unremarkable. Patient's total protein was low at 5.7, calcium low at 7.9, albumin low at 2.8. On admission, sodium was decreased to 133, potassium 3.7, chloride 104, CO2 decreased to 21. Discharge electrolytes showed sodium improved to 134, potassium 3.8, chloride 102, CO2 normalized at 27. Stool cultures showed normal fecal flora with no ova & pericyte seen on O&P study. Stool for WBC did confirm many PMNs present. Verbal report on the stool study obtained through Dr. Marcell's office on the day prior to admission revealed Campylobacter.

HOSPITAL COURSE: Patient was admitted, placed at bedrest, and appropriate hydration with parenteral fluids. Appropriate diagnostic studies were obtained as noted. Gradually he was able to be up and about. LABORATORY STUDIES revealed abnormal sed rate with an ESR of 37 (0-15) and stool was positive X one for occult blood. Verbal report on stool culture obtained prior to admission showed positive for Campylobacter. Clinically by the second hospital day, oral intake had improved and his diarrhea had improved to the point where patient wished to pursue outpatient management.

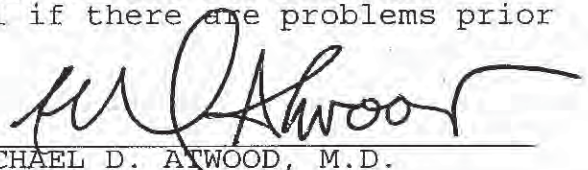
SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TOPEKA, KANSAS

PATIENT NAME: MONTGOMERY, KEVIN W

ACCT#: 2171894

DISCHARGE DISPOSITION: Patient is discharged in stable condition. He was given Cipro 500 mg b.i.d. to continue for five days postoperatively. He'll be seen in FOLLOW-UP next week with Dr. Gerald Marcell, his regular family physician. Patient will call if there are problems prior to his office follow-up.


MICHAEL D. ATWOOD, M.D.

fx: GERALD MARCELL, M.D. (80305)
MICHAEL D. ATWOOD, M.D. (00455)

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\: ch	/: 455
JOB: 70668	ID: 000241556
DD: 06/15/2001	DT: 06/24/2001

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
1700 WEST 7th STREET
TOPEKA, KANSAS 66606-1690

HISTORY AND PHYSICAL

NAME:	MONTGOMERY, KEVIN W	MR#:	10660
ROOM#:	7E-0704-2	DOB:	06/28/1960
ADM:	06/04/2001	PT:	O
DIS:		MSV:	OPB
ACCT#:	2171894		

CHIEF COMPLAINT: Diarrhea, nausea, weakness.

HISTORY OF PRESENT CONDITION: This is a 40-year-old white male presenting with two days of history of nausea and diarrhea with approximately 12 large very watery stools per day associated with some weakness and dizziness but no vomiting or abdominal cramps. During the past three days the patient was not able to drink due to the nausea. Four days ago, approximately, he ate at a Dairy Queen with friends, he doesn't know if anybody else got sick. Nobody else in the family was with him, nobody else in the family got sick eating the home prepared meals meanwhile.

PAST MEDICAL HISTORY: His past medical history is negative.

MEDICATIONS: Negative.

ALLERGIES: No known drug allergies.

FAMILY HISTORY: Negative.

SOCIAL HISTORY: Married, denies any use of alcohol, tobacco or illicit drugs.

REVIEW OF SYSTEMS: Had a fever of 101, was able to bring down with Tylenol. Denies any chest pain, shortness of breath, abdominal cramps, change in the color of the urine, however, he didn't urinate more than two or three times today. Denies any swelling of the feet, headache, dizziness as above, no blurred vision, numbness or muscle weakness. No obvious blood in the stools, no serous discharge in the stools either.

PHYSICAL EXAMINATION: Alert and oriented white male in no apparent distress. Blood pressure lying 85/58 with heart rate of 57, blood pressure sitting 100/67 with heart rate 65. Blood pressure standing 90/68 with heart rate of 69. Afebrile. Respiratory rate 20, oxygen saturation on room air 97%.

HEENT: Dry mucous membranes, conjunctiva pink, nonicteric sclera.

NECK: The neck supple, no thyromegaly, no lymphadenopathy, no bruits over the carotids, no jugular venous distention.

LUNGS: The lungs are clear to auscultation, bilaterally equal.

HEART: S1, S2 regular without murmurs or gallops.

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
TOPEKA, KANSAS

PATIENT NAME: MONTGOMERY, KEVIN W

ACCT#: 2171894

ABDOMEN: Soft, nontender. High pitched bowel sounds, no organomegaly or masses.

EXTREMITIES: Without edema, positive peripheral pulses, bilaterally equal.

NEUROLOGICAL: Intact without any focal symptoms.

The patient received two boluses of normal saline, one liter each, over two hours with Zofran 4 mg IV with some improvement of the nausea. However, after two liters of normal saline blood pressure remains 90/60 and the patient was not able to produce any urine.

MEDICAL DECISION MAKING:

1. Dehydration due to diarrhea due to possible enteritis viral vs bacterial. The patient will be admitted to the medical floor. Dr. Atwood was called for the admission. The patient will be 23 hours observation with IV rehydration with stool cultures if stools available.


GUERGANA P. ORAHOVATZ, M.D.
RESIDENT


MICHAEL D. ATWOOD, M.D.

cc: JAMES L. MCGOVERN JR., M.D. (00439)

fx: MICHAEL D. ATWOOD, M.D. (00455)

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\: klp
JOB: 65389
DD: 06/04/2001

/: 2027
ID: 000235329
DT: 06/05/2001

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER
1700 WEST 7th STREET
TOPEKA, KANSAS 66606-1690

HISTORY AND PHYSICAL

NAME:	MONTGOMERY, KEVIN W	MR#:	10660
ROOM#:	7E-0704-2	DOB:	06/28/1960
ADM:	06/04/2001	PT:	0
DIS:		MSV:	OPB
ACCT#:	2171894		

REASON FOR ADMISSION: Persistent diarrhea with dehydration and orthostatic blood pressure changes.

The patient is a 40-year-old married white male, reports that he has been in his usual state of good health until approximately three days prior to admission. At that time he developed abdominal discomfort with some nausea and anorexia. He did not vomit. The following day he developed repetitive diarrhea associated with fever though he did not measure his fever. He was unable to eat or drink anything without having diarrhea following this. He reports no recent travels outside the state or recent ingestion of well water. He did eat at fast food restaurants on two occasions during the 24 hours prior to the onset of his symptoms, there has been no one else ill at home. His symptoms persisted for two additional days and then yesterday because of continued inability to eat and frequent loose stools he presented to the Emergency Room. He was initially given 2 liters of fluid but continued to have orthostatic blood pressure changes and remained quite weak and exhausted. It was elected to admit him for further intervention.

PAST MEDICAL HISTORY: Remarkable only for a prior right cataract extraction almost 20 years ago. He has had a subsequent intraocular lens placed. He denies other major surgeries or hospitalizations. He is on no regular medications and has no known drug allergies.

FAMILY HISTORY: Remarkable for a brother dying with AIDS in 1987. No other siblings. His parents are both in their 70s and relatively good health though his father had a "mini-stroke" earlier this year.

SOCIAL HISTORY: The patient is married for one year to his present wife and this is the second marriage for both. He has three children by his first marriage and she has four children from her first marriage. The patient is a nonsmoker, nondrinker. He is currently employed as an electrician and that is in Melvern, Kansas.

REVIEW OF SYSTEMS: Generally is unremarkable except for as in the history of present illness.

OBJECTIVE: Vital signs on admission show a presenting blood pressure 100/62, pulse 75, respirations 20, temperature 98.9. In the Emergency Room sitting blood pressure was 100/67 and standing 90/68. The patient is alert and oriented, and a reliable historian.

SAINT FRANCIS HOSPITAL AND MEDICAL CENTER

TOPEKA, KANSAS

PATIENT NAME: MONTGOMERY, KEVIN W

ACCT#: 2171894

HEENT EXAMINATION: Shows the mucous membranes to be dry. There is no scleral icterus or conjunctival injection. The lungs are grossly clear to auscultation.

CARDIAC: Regular rate and rhythm without murmur or gallop appreciated.

ABDOMEN: The abdomen is soft, there is mild diffuse tenderness. There is no rebound tenderness. There is no organomegaly appreciated.

GENITALIA: Adult male.

RECTAL: Performed in the Emergency Room and is not repeated but there was negative heme stool testing reported.

EXTREMITIES: The distal extremities show no edema. Pulses are intact.

ADMITTING LABORATORY STUDIES: Show CBC unremarkable, WBC 9.9, hemoglobin 15.6, hematocrit 43.9, chemistry B on admission showed sodium low 133, potassium 3.7, chloride 104, CO2 decreased to 21, BUN 11, creatinine 0.9.

IMPRESSION:

1. Persistent diarrhea with history of associated fever and chills of undetermined cause.
2. Dehydration secondary to #1.
3. Status post prior right cataract extraction and subsequent intraocular lens placement.

PLAN: The patient is admitted, will have appropriate further intervention including diagnostic stool studies, further studies as indicated pending the patient's clinical course.


MICHAEL D. ATWOOD, M.D.

fx: GERALD MARCELL, M.D. (80305)
MICHAEL D. ATWOOD, M.D. (00455)

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\:	klp	/:	455
JOB:	65453	ID:	000235347
DD:	06/05/2001	DT:	06/05/2001

RLH HEWITT, RANDY L., RN
KSH HOWARD, KELLEY S., RN

MONTGOMERY, KEVIN W
St. Francis Hospital (6.2.5 Live)
Med Admin Report (ps_mar)
FROM: 06/04/01 19:28 TO: 06/05/01 23:00
ROOM: 0704-2 ADM: 06/04/01 19:28
AGE: 40Y SEX: M DR: ATWOOD, M. D.
ID: 2171894 MR: 000010660
REQUESTED: 06/06/01 00:09

Page: 1

* see end of page for Administration Note

■ see end of page for Not-Given reason

HOLD DISCONTINUED

		06/04/01 Day:1					06/05/01 Day:2				
start/stop	ord	03	07	11	15	19	03	07	11	15	19

SCHEDULED MEDICATIONS

Diphenoxylate/Atropine (Lomotil, Lonox)

2.5 MG ORAL

							02:09				
							RLH				

PRN MEDICATIONS

Acetaminophen (Tylenol Extra Strength)

500-1000 MG=1-2 TAB ORAL
Q4H [4-8-12-16-20-23:59]

1000 MG ORAL

06/05 04:00	3										
06/05 04:00	3							09:33			22:26
								KSH			KSH

M:Q4-6H PRN PAIN OR HA NTE 8 TABS (4G) / 24HRS

Diphenoxylate/Atropine (Lomotil, Lonox)

2.5 MG=1 TABLET ORAL
AFTER EACH LOOSE STOOL

06/05 02:18	5							07:53	13:11		
								KSH	KSH		

M:MAXIMUM = 8 TABS / DAY

LAST PAGE

PERM

MONTGOMERY KEVIN W
2171894

6/28/60

DISCHARGE RECORD

MAW OPB K 10660

Discharge Date: 6-6-01 Discharge Time: 1545 Mode: ☐ Ambulatory ☒ WC ☐ Cart

Personal items (valuable, home meds, assist devices) returned: ☒ NA ☐ Yes

Appointment(s)

WHERE:	TELEPHONE NUMBER	DATE	TIME
Dr Marcell in LNK.			

Please check with personal physician regarding need for the following Immunizations:

Diet: No milk products x 24^h then advance diet as tolerated

Activity: as tolerated

may continue Immodium AD over the counter

Pertinent Lab: stool o+p negative

Last Weight: _____ Education Provided to: ☒ Patient ☐ Family ☐ Other _____

Please contact your physician if any questions or problems arise such as temperature elevation, swelling, wound drainage, recurrence of symptoms. Ask-A-Nurse (295-8333) is another resource available 24 hours per day for questions you may have.

THE ABOVE INFORMATION HAS BEEN EXPLAINED TO ME AND QUESTIONS HAVE BEEN ANSWERED.

Patient Signature Kevin Montgomery Date 6-6-01

Other Signature _____ Date _____

Date/Time: 6/6/01 SF 1450. Staff Signature Frederick RN Date/Time: _____ Staff Signature _____



SAINT FRANCIS HOSPITAL AND MEDICAL CENTER TOPEKA, KANSAS

MEDICAL RECORDS

PATIENT ACCOUNT NO. 723338		ADMITTING PHYSICIAN KOVARIK, ERNEST D		NUMBER 172	LOS	PT S	MEDICAL RECORD NO. 10660							
NS RW/BD	SMK	SEX M	MAR M	WGE W	S/H	SEV SUR	ATTENDING PHYSICIAN KOVARIK, ERNEST D	NUMBER 172	AGE 028Y	BIRTH DATE 6/28/60	ADMIT DATE 1/23/89	TIME 0536		
PATIENT NAME MONTGOMERY, KEVIN W							FORMER NAME		FC 1	AC	SRG F	CLERK LWAS	DISCHARGE DATE	TIME
PATIENT ADDRESS BOX 56							MELVERN		KS 66510		COUNTY 70	HOME TELEPHONE 913 549-3427		
SOC. SEC. NUMBER 510 64 7566		RELIGION OTHER		ACC	PREV. ADM. DATE	TREATMENT AUTH.		EMPLOYER PHONE		EMERGENCY PHONE 913 549-3427				
EMPLOYER NAME UNEMPLOYED							EMPLOYER ADDRESS							
EMERGENCY CONTACT MONTGOMERY LORI				REL Z	ADDRESS BOX 56			MELVERN		KS 66510				
ADMITTING DIAGNOSIS APHAKIA & CLOUDY POSTERIOR CAPSULE														
COMMENTS OPS 1/23														
INSURANCE CO. NAME				POLICY NUMBER		GROUP NUMBER		SUBSCRIBER NAME						
1.														
2.														
3.														
REFERRING PHYSICIAN				NUMBER		OS		1		CONSULTANTS:				

PRINCIPLE DIAGNOSIS:

379.31
366.51**ALLERGIC:**

NKA

SECONDARY DIAGNOSIS:

13.72
13.9

FOR MEDICARE PATIENTS ONLY:

I CERTIFY THAT THE NARRATIVE DESCRIPTION OF THE PRINCIPLE AND SECONDARY DIAGNOSIS AND THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

ATTENDING PHYSICIAN2-1-89
DATE OF SIGNATURE

CHART

PRAD-01 (4/88)



ST. FRANCIS HOSPITAL AND MEDICAL CENTER
1700 West 7th Street • Topeka, Kansas 66606 • (913) 295-0000

MONTGOMERY KEVIN W. CONSENT TO SURGICAL OPERATION OR
723338 LLW OPS OTHER PROCEDURE AND ADMINISTRATION
KOVARIK 172 6 28 60 OF ANESTHESIA

1. I hereby authorize Dr. Kovarik and whomever he may designate as his assistants to perform upon

Kevin Montgomery
State name of patient

the following operation or procedures: Polish posterior capsule
and insert intraocular lens right eye.

(State description of procedure)

2. I have been informed and understand the nature and purpose of the operation; the probable consequences thereof; the possible alternative methods of treatment, and the probable risks and hazards involved. The possibility of occurrence of complications, including death, has been explained and is understood by me. I further state that all questions that I have raised with respect to the proposed procedure have been answered to my satisfaction. I have no other questions.

3. I acknowledge that no guarantee or assurance has been made as to the results to be obtained.

It has been explained to me that during the course of the operation unforeseen conditions may be revealed that necessitate an extension of the initial procedure or a different procedure than that set forth above. I therefore authorize and request the above-named physician or his designated consultants to perform such procedures that are in his judgment necessary and desirable.

5. I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service, with the exception of

None
(If none, state "none")

6. I also consent to the study and retention or disposal of tissue or parts which may be removed during the above operation or procedure.

WITNESSES TO SIGNATURES:

Paul G. Fulton Jr
(Name)

SEAMA
(Address)

(Name)

(Address)

Kevin W. Montgomery 1-23-89 6:07 AM
(Patient's signature) (Date & Time)

(Signature of other person authorized to consent for minor or incompetent patient)

(Authority to consent-relationship)

Patient: *Montgomery, Kevin*
Age: *28*

Ernest D. Kovarik, M.D., F.A.C.S.

Patient: Montgomery, Kevin
Age: 28

Date: 1-20-89

Referral: Tashmeyer

HISTORY

Chief Complaint: CVA - OD, aphasia

Ocular History: 12/81 20/20 5 IOL OD
Keratits = 'C' - dry eye

Medical History: joint GH

Surgical History:

Current Medications: Q

Allergies: NKA

Significant Family History: CA
'Lazy Eye'

PHYSICAL EXAM

General: Level of orientation - alert - appropriate

VS <u>Bp 124/70</u> <u>+98.2</u>	ENT
Cardiac	Abd.
Resp.	Musculoskeletal
Neuro.	

Ernest D. Kovarik, M.D.



ST. FRANCIS HOSPITAL AND MEDICAL CENTER

TOPEKA, KANSAS

OPERATIVE RECORD

Name: MONTGOMERY, Kevin W.
Account No.: 723338

Room No: OP
Age: 28

Medical Record No.: 10660
Date of Operation: 1/23/89

Surgeon: E. J. Kovarik, M. D.

Operation: Polishing of the Elschmig's pearls of posterior capsule and secondary implant of a posterior chamber lens, right aphakic eye..

Preoperative Diagnosis: Aphakic right eye with Elschmig's pearls on posterior capsule.

Postoperative Diagnosis: Same.

The style of lens is Coopervision Cilco styel 751.61, Power: 16.0. Serial No. 166147.001.

Anesthesia was topical and retrobulbar with local standby.

Procedure: In the holding area the lids were prepped with alcohol in the routine fashion. A 50% mixture of .75 Sensorcaine with 2% Carbocaine with injected in a modified Van Lin infiltration for akinesia using 12 ccs then using 3 ccs of the same mixture retrobulbarly for anesthesia with 1/4 cc over the superior rectus for anesthesia. The patient was then transferred to the operating suite and onto the table and positioned comfortably. The Honan's cuff had been on for approximately 30 minutes.

second preoperative Betadine solution prep was carried out and the lids were taped the routine fashion. The operating microscope was used. The speculum was placed between the lids for retraction and a 4-0 silk suture was placed beneath the superior rectus tendon for retraction.

170 degree pirotomy was carried out superiorly and hemostasis was obtained with bipolar wet field cautery. A partial limba groove from 11 mms was carried out superiorly, and the second two step incision was made at 11 o'clock. Through this I inserted the Kratz polisher and was able to polish the posterior capsule very easily. I now enlarged the opening and placed the irrigation aspiration unit and aspirated the free cortical material and opened up the bag inferiorly but the posterior capsule remaining intact.

The suction was now opened for the full 11 mms. I instilled Healon. A posterior chamber lens was now placed with the inferior loops, and bag superiorly in the sulcus. There were no complications. The Healon was removed. The anterior chamber was deepened with Miostat and the pupil came down to 3 mms. and round. A PR which was carried out during his initial surgery was at 11 o'clock. The section was now closed with four interrupted crossed 10-0 nylon sutures without any complications. The conjunctiva was brought down over the section, the 4-0 silk suture was removed from beneath the superior rectus tendon. The speculum and drapes were removed. A light patch and shield were placed on the eye and the patient sent to recovery in the outpatient department and he will be seen where instructions for discharge will be allowed.

Ernest D. Kovarik, M. D.

SIGNED

M.D.

rk
dd: 1/23
cc: 1/24
OPERATIVE RECORD
cc: Larry Tagtmeyer, O. D. Emporia

ANESTHESIA RECORD

PHYSICAL STATUS

1 2 3 4 5 E

Age: 25 Sex: M

IV: Site L4th Pre-OR / OR

Needle Size 20 IV Status 04

BP 124/76 P 64

Resp. 20 Temp. 97.6

HGB HCT

Blood Avail. /

[illegible]